STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012582	A. BUILDING: _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE SENIOR LIVING LLC	4411 PARK PLACE DR FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: May 20 & 21, 2013 Facility number: 012582 Provider number: 012582 AIM number: N/A Survey team: Rick Blain, RN - TC Tim Long, RN Carol Miller, RN Diane Nilson, RN Census bed type: Residential: 116 Total: 116 Census payor type: Medicaid: 14 Other: 102 Total: 116 Sample: 8 Park Place Senior Living LLC was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality Review 05/21/13 by Lisa McColly	R 000		